TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
BOARD OF PHARMACY
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
(615) 253-1299 OR FAX (615) 741-2722
https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board.html

INTERNSHIP AFFIDAVIT

NAME *Last* *First* *Middle Initial*

( )

ADDRESS *Street* *Apt. Number* *Phone Number*

- -

City *State* *Zip* *Intern's Social Security Number*

I hereby certify that the above named Pharmacist Intern was trained according to the requirements of the Rules and Regulations of the Tennessee Board of Pharmacy. I certify that these hours were acquired during my presence and under my personal supervision:

PRINT *Name of Pharmacist Preceptor* *Name of Pharmacy*

Address of Pharmacy *Pharmacy License Number*

( )

City *State* *Zip* *Pharmacy Phone Number*

Beginning Month/Day/Year	Ending Month/Day/Year	Number of Hours

* Pay records may be attached (it is not a requirement) but a total must be entered in the number of hours square. The board will not be responsible for totaling the hours.

Total Hours (all hours on this page) ____________

Signature of Pharmacist Preceptor *License No.*

NOTARY PUBLIC: I attest that the above signature (s) of ______________________________

sworn to and subscribed to before me this __________ day of ______________________________ ,

My commission expires ____________________ *Notary Signature*______________________________

* This form is for hours worked in Tennessee only.

* Hours earned in states other than Tennessee must be certified to Tennessee by the Board of Pharmacy in the state where the work was performed.